CITY COUNCIL AGENDA ITEM COVER MEMO

Agenda Item Number_____

Meeting Type: Regular

Meeting Date: 9/27/2012

Action Requested By:
Human Services

Agenda Item Type
Resolution

Subject Matter:

Agreement between the City of Huntsville and VSP for the City's group vision insurance.

Exact Wording for the Agenda:

Resolution authorizing the mayor to execute a renewal agreement between the City of Huntsville and VSP for the purpose of providing the City's group vision benefits.

Note: If amendment, please state title and number of the original

Item to be considered for: Action

Unanimous Consent Required: No

Briefly state why the action is required; why it is recommended; what Council action will provide, allow
and accomplish and; any other information that might be helpful.

This contract is needed to provide for the yearly renewal of voluntary vision insurance for employees.

Associated Cost: _____

Budgeted Item: Select...

MAYOR RECOMMENDS OR CONCURS: Select...

Department Head: _____ Date: 9/19/2012

revised 3/12/2012

ROUTING SLIP
CONTRACTS AND AGREEMENTS

Originating Department: **Human Resouces** Council Meeting Date: **9/27/2012**

Department Contact: **Deloise Manning** Phone # **256-427-5241**

Contract or Agreement: **VSP (Vision Service Plan)**

Document Name: **Renewal Letter and Business Associate Agreement**

City Obligation Amount:

Total Project Budget:

Uncommitted Account Balance:

Account Number:

Procurement Agreements

Select...	Select...

Grant-Funded Agreements

Select...	Grant Name:

Department	Signature	Date
1) Originating	Byron K Johnson	9/20/12
2) Legal	Mary B. Cates	9/20/12
3) Finance		9/21/12
4) Originating		
5) Copy Distribution		
a. Mayor's office (1 copies)		
b. Clerk-Treasurer (Original & 2 copies)		

RESOLUTION NO. 12-____

WHEREAS the City of Huntsville wishes to continue to offer voluntary group vision insurance to the City;

WHEREAS the City of Huntsville desires to implement the Additional Signature Plan Enhancements offered by Vision Service Plan (VSP) to include a Diabetic Eyecare Plus Benefit and a Contact Lens Benefit change;

WHEREAS the City of Huntsville, does hereby declare in accordance with Code of Alabama (1975) that the Mayor be, and he is hereby authorized to enter into an agreement between the City of Huntsville and VSP, on behalf of the City of Huntsville, a municipal corporation in the State of Alabama, which said agreement is substantially in words and figures similar to that certain document attached hereto and identified as Group Vision Care Policy, and related documents, including a separate but related Business Associate Agreement, consisting of thirty-eight (38) pages and the effective date of January 1, 2013, and the date of September 27, 2012, appearing on the margin of the first page, together with the signature of the President or President Pro Tem of the City Council, an executed copy of said document being permanently kept on file in the Office of the City Clerk-Treasurer of the City of Huntsville, Alabama.

ADOPTED this the 27th day of September, 2012.

_____
President of the City Council of
the City of Huntsville, Alabama

APPROVED this the 27th day of September, 2012.

_____
Mayor of the City of
Huntsville, Alabama

VSP
Vision care for life

Erik Gawthorpe
Regional Manager

June 15, 2012

Ms. Holly Woodson
Cobbs, Allen & Hall Inc.
115 Office Park Dr
Suite 200
Mountain Brook, AL 35223-2423

Dear Holly:

As a valued customer of VSP since January 1, 2010, we hope our mutual client, *City of Huntsville*, and their employees have enjoyed a positive outcome with all aspects of our services.

VSP reviewed your program and developed rates based on the experience of your vision care program. These rates are outlined below. Many factors are considered when determining rates, such as utilization, claim frequency, retention and trends.

Diabetic Eyecare Plus Benefit:
Diabetes doesn't have to severely impact your bottom line. The Diabetic Eyecare Plus Program provides coverage for additional eyecare services targeted specifically for members with Type 1 or Type 2 diabetes. The program also supports that a VSP doctor should be a member's first call for all vision-related concerns and not just for a routine eyecare. The copay for these additional services will be $20.

ADDITIONAL SIGNATURE PLAN ENHANCEMENTS:

2012 Contact Lens Benefit Changes:
Beginning, January 1, 2012, our new contact lens benefit design will separate the contact lens exam (fitting and evaluation) from material coverage. Members choosing contact lenses will now receive a covered-in-full contact lens exam after a not to exceed $60. copay. This copay applies to both standard *and* premium fit contact lens wearers. VSP is the only vision plan providing this level of coverage for premium fit wearers. Members will also continue to receive a 15% discount on all contact lens exam services. This new benefit design also allows members to use their full contact lens allowance toward contact lenses.

Group Name:	City of Huntsville
Group Number:	30015389
Plan Design:	Choice Plan – Exam and lenses every 12 months, and frames every 24 months
Copayment:	$15 Exam/$15 Materials
Current Allowances:	$130 Frame / $130 ECL
Renewal Period:	January 1, 2013 – December 31, 2014 (24 months)
Current Active Rates:	$6.34 / 12.09 / 17.11
Current COBRA Rates:	$6.47 / 12.33 / 17.45
Renewal Active Rates:	**$6.66 / 12.69 / 17.96**
Renewal COBRA Rates:	**$6.79 / 12.94 / 18.32**

Please have the appropriate group representative sign the renewal below and fax or email a copy of this renewal to Erik Gawthorpe at erik.gawthorpe@vsp.com and Janet Jones at janet.jones@vsp.com or fax (770) 263-6008.

We appreciate your business and value our relationship with your organization.

President of the City Council of the
City of Huntsville, Alabama
Date;_____

Cordially,

Erik Gawthorpe

Erik Gawthorpe

_____
Authorized Group Representative Signature

VSP® Vision Care

VSP Diabetic Eyecare Plus Program℠

If you have type 1 or type 2 diabetes, you can get both your routine eyecare and follow-up diabetic eyecare services from your VSP® Vision Care doctor—the one who knows your eyes best.

People with diabetes often aren't aware they have diabetic eye disease. That's because in the early stages of the disease, few symptoms may appear until after damage has already occurred. An annual eye exam from a VSP doctor can help prevent most diabetes-related blindness.

VSP doctors take the time to get to know you and your eyes. They can detect changes in your eye health from year to year. Your VSP doctor can consult and coordinate with your primary care physician to ensure you're getting the best care—keeping you and your eyes healthy.

It's easy to use.

You never need a referral and you pay only a copay for the diabetes-related eyecare services.

- **Find the right VSP doctor for you.** You'll find plenty to choose from at **vsp.com** or by calling **800.877.7195**.
- **Already have a VSP doctor?** At your appointment, tell them you have VSP.

That's it! Your VSP doctor will handle the rest.

Visit **vsp.com** to learn how diabetes affects your eyes and find out how to keep them healthy.

The VSP Diabetic Eyecare Plus Program coverage is only available through a VSP doctor. This coverage is for diabetes-related eyecare services and doesn't cover routine eye exams. Contact your VSP doctor for an appointment to use your routine eyecare benefits.

JOB#7933CM 10/11

VSP Choice Plans

Below is a summary of benefits available with the VSP Signature and Choice Plans through VSP Preferred Providers.
For a complete proposal or for a network access report, please contact your VSP Representative.

City of Huntsville

	Current Plan VSP Choice Plan® *Full-service Plan*	*Renewal Plan* VSP Choice Plan® *Full-service Plan*
Provider Network	**Choice Network** 27,000 preferred providers 45,000 access points	✓
Plan Frequencies	Exam/Lenses/Frame 12/12/24	✓
Copays	$15 Exam / $15 Materials	✓
Exam Services	Thorough WellVision Exam® covered in full[1]	✓
Lenses	Glass or plastic, single vision, lined bifocal, lined trifocal, or lenticular prescription lenses are covered in full[1]	✓
Lens Options	The most popular lens options are covered in full with a copay, saving our members an average of 20-25%[2]	✓
	Patient cost[3]: Progressives: $55 Anti-reflective: $41 Photochromics: $70 Scratch resistant coating: $ 0 Polycarbonate: $ 0	✓
	Dependent children are eligible for covered in full polycarbonate prescription lenses	✓
Frame	Frames are covered in full[1] up to the retail allowance of $130 and/or $50 wholesale	✓
	20% off any amount above the allowance	✓
	Frame allowance backed by a wholesale guarantee, meaning VSP fully covers more frames compared to retail allowance plans	✓
Contact Lenses	15% off contact lens services, excluding materials	Contact lens exam (fitting and evaluation) is covered in full with a copay not to exceed $60 for all contact lens wearers (standard and premium fit); members will also receive 15% off of the contact lens exam and all other contact lens services
	Instead of eyeglasses, elective contact lens materials are covered up to $130 toward any type of prescription contact lenses	✓
	Exclusive offers for VSP members include: Mail-in rebate savings[4] up to $110 on eligible Bausch & Lomb contacts and up to $125 on eligible ACUVUE Brand Contact Lenses	✓
	Necessary contact lenses are covered-in-full[1] for members who have specific conditions for which contact lenses provide better visual correction.	✓

	Current Plan VSP Choice Plan® Full-service Plan	Renewal Plan VSP Choice Plan® Full-service Plan
Diabetic Eyecare Plus Program℠	N/A	Provides additional coverage through medical diagnosis and procedure codes specifically targeted toward type 1 and type 2 diabetics
VSP GetFIT Program®	A free customizable wellness program for all your members and their dependents	✓
Laser VisionCare℠ Program	Discounts averaging 15-20% off or 5% off a promotional offer for laser surgery including PRK, LASIK, and Custom LASIK[5]	✓
Value-added Benefits	20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses	✓
Open Access Schedule	Eye Exam: $35 Single Vision: $25 Lined Bifocal: $40 Lined Trifocal: $60 Lenticular $91 Progressive: $40 Frame: $45 Elective Contact Lenses: $115 Medically Necessary Contact Lenses: $210	✓

[1] Less any applicable copay
[2] Most popular lens options include progressives, anti-reflective, photochromics, scratch resistant coating, polycarbonate, plastic dyes, and UV protection. All other lens options available at a 20% discount.
[3] Prices shown reflect the standard option price, prices on premium options may vary. Prices are valid only through VSP Preferred Providers and are subject to change without notice.
[4] Rebates subject to change.
[5] Using wavefront technology with the microkeratome surgical device only. Other LASIK procedures may be performed at an additional cost to the member. Laser VisionCare discounts are only available from VSP-contracted facilities.
[6] 30% discount applies to glasses purchased the same day as the member's eye exam from the same VSP Preferred Provider who provided the exam. Members will also receive 20% off unlimited additional pairs of glasses valid through any VSP Preferred Provider within 12 months of the last covered exam.
[7] The copay amounts are example amounts only and may be customized to meet specific needs.

VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670

GROUP VISION CARE POLICY

Group Name	**CITY OF HUNTSVILLE**
Policy Number	**30015389**
State of Delivery	**ALABAMA**
Effective Date	**JANUARY 1, 2013**
Policy Term	**TWENTY-FOUR (24) MONTHS**
Premium Due Date	**FIRST DAY OF MONTH**

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN INSURANCE COMPANY ("VSP") agrees to insure certain individuals under this Group Vision Care Policy ("Policy") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, including any Exhibits or state-specific Addenda, which are a part of this Policy.

James M. McGrann, Secretary

TABLE OF CONTENTS

I.
DEFINITIONS

Key terms used in this Policy are defined:

1.01. **ADMINISTRATIVE SERVICES PROGRAM**: A group vision care plan whereby Group pays VSP for the Plan Benefits in addition to a monthly administrative fee.

1.02. **BENEFIT AUTHORIZATION**: Authorization from VSP identifying the individual named a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled.

1.03. **CONFIDENTIAL MATTER**: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons obtained while providing Plan Benefits hereunder.

1.04. **COPAYMENTS**: Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.

1.05. **COVERED PERSON**: An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under this Policy.

1.06. **ELIGIBLE DEPENDENT**: Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP in Article VI of this Policy under which such Enrollee is covered.

1.07. **EMERGENCY CONDITION**: A condition, with sudden onset and acute symptoms, that requires the Insured to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.

1.08. **ENROLLEE**: An employee or member of Group who meets the criteria for eligibility specified under Article VI. ELIGIBILITY FOR COVERAGE.

1.09. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

1.10. **GROUP**: An employer or other entity which contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

1.11. **GROUP APPLICATION**: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Covered Persons of VSP.

1.12. **GROUP VISION CARE POLICY (also, "THE POLICY")**: The Policy issued by VSP to a Group, under which its Enrollees or members, and their Eligible Dependents are entitled to become Covered Persons of VSP and receive Plan Benefits in accordance with the terms of such Policy.

1.13. **MEMBER DOCTOR**: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

1.14. **NON-MEMBER PROVIDER**: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

1.15. **PLAN BENEFITS**: The vision care services and vision care materials which Covered Person is entitled to receive by virtue of coverage under this Policy, as defined in the Schedule of Benefits attached hereto as Exhibit A.

1.16. **RENEWAL DATE**: The date when the Policy shall renew, or terminate if proper notice is given.

1.17. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.

1.18. **SCHEDULE OF PREMIUMS**: The document, attached hereto as Exhibit B, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

II.
TERM, TERMINATION, AND RENEWAL

2.01. **Plan Term**: This Policy is effective on the Effective Date and shall remain in effect for the Policy Term. At the end of the Policy Term, the Policy shall renew on a month to month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Policy Term that such party is unwilling to renew the Policy. If such notice is given, the Policy shall terminate at 11:59 p.m. on the last day of the Policy Term unless the parties agree on its renewal of the Policy. If the Policy continues on a month to month basis after the Policy Term, either party may terminate the Policy upon thirty (30) days advance notice to the other party.

If VSP issues written renewal materials to Group at least sixty (60) days before the end of the Policy Term and Group fails to accept the new terms and/or rates in writing prior to the end of the Policy Term, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Term.

2.02. **Early Termination Provision**: The Premium rate payable by Group to VSP under this Policy is based on an assumption that VSP will receive these amounts over the full Policy Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Policy Term. If Group terminates this Policy before the end of the Policy Term or before the end of any subsequent renewal terms, for any reason other than material breach by VSP, Group will remain liable to VSP for the lesser amount of any deficit incurred by VSP or the payments which Group would have paid for the remaining term of this Plan, not to exceed one year. A deficit incurred by VSP will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by VSP from Group. Net premiums shall mean premiums paid by Group minus any applicable retention amounts and/or broker commissions. Group agrees to pay VSP within thirty-one (31) days of notification of the amount due.

III.
OBLIGATIONS OF VSP

3.01. **Coverage of Covered Persons**: VSP will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of who shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Group to complete, sign and forward to VSP a Group Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

Following the enrollment of the Covered Persons, VSP will provide Group with Member Benefit Summaries for distribution to Covered Persons. Such Member Benefit Summaries will summarize the terms and conditions set forth in this Policy.

3.02. **Provision of Plan Benefits**: Through its Member Doctors (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-Member Provider) VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits, Exhibit A hereto, subject to any limitations, exclusions, or Copayments therein stated. Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits from a Member Doctor, the Covered Person must schedule an appointment and identify himself as a VSP Covered Person so the Member Doctor can obtain Benefit Authorization from VSP. VSP shall provide Benefit Authorization to the Member Doctor to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Covered Person to obtain Plan Benefits. VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Group and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the Member Doctor that payment will be made, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP has received a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

3.03. **Provision of Information to Covered Persons**: Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and how to use them. A copy of this Policy shall be placed with Group and also will be made available at the offices of VSP for any Covered Persons. VSP shall provide Group with an updated list of Member Doctors' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the Member Doctor directory through contacting VSP's Customer Service Department's toll-free Customer Service telephone line, VSP's Web site at www.vsp.com, or by written request.

3.04. **Preservation of Confidentiality**: VSP shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Member Doctors, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Policy, including but not limited to sharing information with medical information bureaus, or complying with applicable law. Covered Persons and/or Groups that want more information on VSP's Confidentiality policy may obtain a copy of the policy by contacting VSP's Customer Service Department or VSP's Web site at www.vsp.com.

3.05. **Emergency Vision Care**: When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If Group has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

IV.
OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees**: An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by VSP and Group. By the Effective Date of this Policy, Group shall provide VSP with eligibility information, in a mutually agreed upon format and medium, to identify all Enrollees who are eligible for coverage under this Policy as of that date. Thereafter, Group shall supply to VSP by the last day of each month, eligibility information sufficient to identify all Enrollees to be added to or deleted from VSP's coverage rosters for the next month. The eligibility information shall include designation of each Enrollee's family status if dependent coverage is provided. Upon VSP's request, Group shall make available for inspection records regarding the coverage of Covered Persons under this Policy.

4.02. **Payment of Premiums**: By the last day of each month, Group shall remit to VSP the premiums payable for the next month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Policy. The Schedule of Premiums incorporated in this Policy as Exhibit B provides the premium amount for each Covered Person. Only Covered Persons for whom premiums are actually received by VSP shall be entitled to Plan Benefits under this Policy and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Covered Person is not received on time, VSP may terminate all rights of such Covered Person. Such rights may be reinstated only in accordance with the requirements of this Policy.

VSP may change the premiums set forth in Exhibit B (Schedule of Premiums) by giving Group at least sixty (60) days advance written notice. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by VSP and Group.

Notwithstanding the above, VSP may increase premiums during a Policy Term by the amount of any tax or assessment not now in effect but subsequently levied by any taxing authority, which is attributable to premiums VSP received from Group.

4.03. **Grace Period**: Group shall be allowed a grace period of thirty-one (31) days following the premium payment due date to pay premiums due under this Policy. During said grace period, this Policy shall remain in full force and effect for all Covered Persons of Group. VSP will consider late payments at the time of Policy renewal. Such payment may impact Group's premium rates in future Policy Terms.

If Group fails to make any premiums payment due by the end of any grace period, VSP may notify Group that the premiums payment has not been made, that coverage is canceled and that Group is responsible for payment for all Plan Benefits provided to Covered Persons after the last period for which premiums were paid in full, including the grace period through the effective date of termination. Group shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy.

4.04. **Distribution of Required Documents**: Group shall distribute to Enrollees any disclosure forms, plan summaries or other material required to be given to plan subscribers by any regulatory authority. Such materials shall be distributed by Group no later than thirty (30) days after the receipt thereof, or as required under state law.

4.05. **Risk-to-ASP Conversion Provision**: Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event Group wishes to convert its method of funding from a risk program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services program.

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

5.01. **General**: By this Policy, Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, this Policy may be amended or terminated by agreement between VSP and Group as indicated herein, without the consent or concurrence of Covered Persons. This Policy, and all Exhibits, Riders and attachments hereto, constitute VSP's sole and entire undertaking to Covered Persons under this Policy.

As conditions of coverage, all Covered Persons under this Policy have the following obligations:

5.02. **Copayment for Services Received**: Where, as indicated in Exhibit A (Schedule of Benefits), Copayments are required for certain Plan Benefits, Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Member Doctor the date services are rendered.

5.03. **Obtaining Services from Member Doctors**: Benefit Authorization must be obtained prior to receiving Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits, the Covered Person must select a Member Doctor, schedule an appointment, and identify himself as a Covered Person so the Member Doctor can obtain Benefit Authorization from VSP. Should the Covered Person receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the Member Doctor will be considered a Non-Member Provider and the benefits available will be limited to those for a Non-Member Provider, if any.

5.04. **Submission of Non-Member Provider Claims**: If Non-Member Provider coverage is indicated in Exhibit A (Schedule of Benefits), written proof (receipt and the Covered Person's identification information) of all claims for services received from Non-Member Providers shall be submitted by Covered Persons to VSP within three hundred sixty-five (365) days of the date of service. VSP may reject such claims filed more than three hundred sixty-five (365) days after the date of service.

Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of three hundred sixty-five (365) days after the date of service.

5.05. **Complaints and Grievances**: Covered Persons shall report any complaints and/or grievances to VSP at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to VSP verbally or in writing. A Covered Person may submit written comments or supporting documentation concerning his complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

5.06. **Claim Denial Appeals**: If, under the terms of this Policy, a claim is denied in whole or in part, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) Initial Appeal: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP Enrollee's name, the VSP Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

b) Second Level Appeal: If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) **Other Remedies**: When Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or Group should advise Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(l)(B)], Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

5.07. **Time of Action**: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under this Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with VSP. No such action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices were submitted to VSP, in accordance with the terms of this Policy.

5.08. **Insurance Fraud**: Any Group and/or person who intends to defraud, knowingly facilitates a fraud or submits an application or files a claim with a false or deceptive statement, is guilty of insurance fraud. Such an act is grounds for immediate termination of the Policy for the Group or individual that committed the fraud.

VI.
ELIGIBILITY FOR COVERAGE

6.01. **Eligibility Criteria**: Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

(a) **Enrollees**: To be eligible for coverage, a person must:

(1) currently be an employee or member of the Group, and

(2) meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

(b) **Eligible Dependents**: If dependent coverage is provided, the persons eligible for dependent coverage are:

(1) the legal spouse of any Enrollee, and

(2) any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; Such dependents shall be eligible until the end of the month in which they attain the age of 26 years.

(3) as further defined by Group.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force; PROVIDED that satisfactory proof of the dependent's incapacity can be furnished to VSP within thirty-one (31) days of the date the Eligible Dependent's coverage would have otherwise terminated or at such other times as VSP may request proof, but not more frequently than annually.

6.02. **Documentation of Eligibility:** Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:

(a) for an Enrollee, the individual's name and Social Security Number have been reported by Group to VSP in the manner provided hereunder, and

(b) for changes to an Eligible Dependent's status, the change has been reported by the Group to VSP in the manner provided herein. As stated in Paragraph 4.01 above, VSP may elect to audit Group's records in order to verify eligibility of Enrollees and dependents and any errors. Subject to the terms of Paragraph 4.03 above, only persons on whose behalf premiums have been paid for the current period shall be entitled to Plan Benefits hereunder. If a clerical error is made, it will not affect the coverage a Covered Person is entitled under the Policy.

6.03. **Retroactive Eligibility Changes:** Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by VSP. VSP may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

6.04. **Change of Participation Requirements, Contribution of Fees, and Eligibility Rules:** Composition of the Group, percentage of Enrollees covered under the Policy, and Group's contribution and eligibility requirements, are all material to VSP's obligations under this Policy. During the term of this Policy, Group must provide VSP with written notice of changes to its composition, percentage of Enrollees covered, contribution and eligibility requirements. Any change which materially affects VSP's obligations under this Policy must be agreed upon in writing between VSP and Group and may constitute a material change to the terms and conditions of this Policy for purposes of Paragraph 4.02. Nothing in this section shall limit Group's ability to add Enrollees or Eligible Dependents under the terms of this Policy.

6.05. **Change in Family Status:** In the event Group is notified of any change in a Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of Dependent, etc.] Group shall provide notice of such change to VSP via the next eligibility listing required under Paragraph 4.01. If notice is given, the change in the Covered Person's status will be effective on the first day of the month following the change request, or at such later date as may be requested by or on behalf of the Covered Person. Notwithstanding any other provision in this section, a newborn child will be covered during the thirty-one (31) day period after birth, and an adopted child will be covered for the thirty-one (31) day period after the date the Enrollee or Enrollee's spouse acquires the right to control that child's health care. To continue coverage for a newborn or adopted child beyond the initial thirty-one (31) day period, the Group must be properly notified of the Enrollee's change in family status and applicable premiums must be paid to VSP.

VII.
CONTINUATION OF COVERAGE

7.01. **COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

VIII.
ARBITRATION OF DISPUTES

8.01. **Dispute Resolution:** Any dispute or question arising between VSP and Group or any Covered Person involving the application, interpretation, or performance under this Policy shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration.

8.02. **Procedure:** The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

8.03. **Choice of Law:** If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery of the Policy shall be the applicable law.

IX.
NOTICES

9.01. **Required Notices**: Any notices required under this Policy to either Group or VSP shall be in written format. Notices sent to Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by the Group. Notices sent to VSP shall be sent to the address shown on the first page of this Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

X.
MISCELLANEOUS

10.01. **Entire Policy:** This Policy, the Group Application, the Evidence of Coverage, and all Exhibits, Riders and attachments hereto, and any amendments hereto, constitute the entire agreement of the parties and supersedes any prior understandings and agreements between them, either written or oral. Any change or amendment to the Policy must be approved by an officer of VSP and attached hereto to be valid. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Group for distribution to Enrollees do not constitute a part of this Policy.

10.02. **Indemnity:** VSP agrees to indemnify, defend and hold harmless Group, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of VSP, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Group agrees to indemnify, defend and hold harmless VSP, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Group, its officers or employees to perform any of the duties or responsibilities specified herein.

10.03. **Liability:** VSP arranges for the provision of vision care services and materials through agreements with Member Doctors. Member Doctors are independent contractors and responsible for exercising independent judgment. VSP does not itself directly furnish vision care services or supply materials. Under no circumstances shall VSP or Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

10.04. **Assignment:** Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto except as expressly authorized herein.

10.05. **Severability:** Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

10.06. **Governing Law:** This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in compliance with, applicable federal or state statutes or regulations is hereby amended to conform with the requirements of such statutes or regulations, now or hereafter existing.

10.07. **Gender:** All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

10.08. **Equal Opportunity**: VSP is an Equal Opportunity and Affirmative Action employer.

10.09. **Communication Materials**: Communication materials created by Group which relate to this vision care Policy must adhere to VSP's Member Communication Guidelines distributed to Group by VSP. Such communication materials may be sent to VSP for review and approval prior to use. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Group's materials meet any applicable legal or regulatory requirements, including, but not limited to, ERISA requirements.

EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
VSP Choice Plan

GENERAL

This Schedule lists the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Policy to which it is attached.

Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a Copayment of $15.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $15.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 35.00*

Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Subsequent regular eye examinations once every plan year beginning on January 1st.

*Less any applicable Copayment.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in full*	Up to $ 25.00*
Bifocal	Covered in full*	Up to $ 40.00*
Trifocal	Covered in full*	Up to $ 60.00*
Lenticular	Covered in full*	Up to $ 91.00*

Available once every plan year beginning on January 1st.

Frames	Covered up to Plan Allowance*	Up to $ 45.00*

Available once every other plan year beginning on January 1st.
*Less any applicable Copayment.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

Lens Options

Scratch coating	Covered in full	Not Covered
Polycarbonate lenses	Covered in full	Not Covered

CONTACT LENSES

Contact lenses are available once every plan year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for one plan year.

Necessary-

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Insured's Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured to be eligible for Necessary Contact Lenses.

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials	**Professional Fees and Materials**
Covered in full*	Up to $210.00*

Elective -

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Elective Contact Lens fitting and evaluation** services are covered in full once every plan year, after a maximum $60.00 Copayment.	
Materials	**Professional Fees and Materials**
Up to $130.00	Up to $115.00

*Subject to Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

LOW VISION BENEFIT

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplementary Testing	Covered in Full	Up to $125.00

Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is $1000.00 (excluding Copayment) every two years.

NON-MEMBER PROVIDER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Policy will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Policy which are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Corrective vision treatment of an Experimental Nature;

- Costs for services and/or materials above Plan Benefit allowances;

- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF VSP's OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

EXHIBIT B

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF PREMIUMS
VSP Choice Plan

VSP shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below:

$	6.66	per month for each eligible Enrollee without Eligible Dependents.
$	12.69	per month for each eligible Enrollee with one Eligible Dependent.
$	17.96	per month for each eligible Enrollee with two or more Eligible Dependents.

COBRA – DIVISION 0003

$	6.79	per month for each eligible Enrollee without Eligible Dependents.
$	12.94	per month for each eligible Enrollee with one Eligible Dependent.
$	18.32	per month for each eligible Enrollee with two or more Eligible Dependents.

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the Initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Plan or Certificate of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another VSP Network Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

DIABETIC EYECARE PLUS PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula

ADDENDUM

TO GROUP VISION CARE POLICY
VISION SERVICE PLAN INSURANCE COMPANY
FOR THE STATE OF ALABAMA

Section VIII. **Arbitration of Disputes** is hereby deleted in its entirety.

Business Associate Agreement
Effective Date: 1/1/2013

1. Definitions

(a) "Business Associate" shall mean Vision Service Plan (VSP).
(b) "Covered Entity" shall mean **City of Huntsville** group vision plan.
(c) "Individual" shall have the same meaning as the term "individual" is used in 45 CFR 160.103, and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
(d) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information in 45 CFR part 160 and part 164, subparts A and E.
(e) "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate on behalf of Covered Entity.
(f) "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" as defined in 45 CFR 160.103.
(g) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.
(h) "Secretary" shall mean the Secretary of the Department of Health and Human Services or designee.
(i) "Security Rule" shall mean the Security Standards in 45 CFR parts 160, 162, and 164.

Terms used but not otherwise defined in this Agreement shall have the same meaning as the meaning ascribed to those terms in the Health Information Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA"), the Health Information Technology Act of 2009, ("HITECH Act"), as set forth in Sections 13400 through 13424, inclusive, of Public Law 111-5, or any current and future regulations promulgated under either. HIPAA, HITECH Act and any current and future regulations promulgated under either are collectively referred to herein as the "Regulations".

2. Obligations and Activities of Business Associate

Business Associate agrees:

(a) Not to use or further disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

(b) To limit uses and disclosures of protected health information to the minimum necessary for that use or disclosure.

(c) To use appropriate safeguards to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.

(d) To mitigate, to the extent practicable, any harmful effect that is known to Business Associate, of a use or disclosure of Protected Health Information by Business Associate, in violation of the requirements of this Agreement.

(e) To immediately report to Covered Entity, any use or disclosure of the Protected Health Information, including Electronic Protected Health Information, not provided for by this Agreement.

(f) To ensure that any agent, including any subcontractor, to whom it provides Protected Health Information or Electronic Protected Health Information, received from, or created or received by, Business Associate, on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate under this Agreement.

(g) To provide access to Protected Health Information in a Designated Record Set, in the time and manner, requested and/or directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.

(h) To make any appropriate amendment(s) to Protected Health Information in a Designated Record Set, pursuant to 45 CFR 164.526, and in the time and manner, as Covered Entity or Individual directs or agrees.

(i) To conduct, where applicable, electronic transactions, for which the Department of Health and Human Services has established standards, on behalf of the Covered Entity pursuant to the requirements in 45 CFR Part 162, and to require that any agent or subcontractor involved in conducting these transactions maintains compliance with these requirements.

(j) To make internal practices, books, and records relating to the use and disclosure of Protected Health Information available to Covered Entity, or at the request of Covered Entity to the Secretary, in the time and manner designated by the Covered Entity or the Secretary, for purposes of determining Covered Entity's compliance with the Privacy Rule.

(k) To document disclosures of Protected Health Information and related information as required of Covered Entity to respond to any request from Individual for an accounting of such disclosures in accordance with 45 CFR 164.528.

(l) To provide to Covered Entity or Individual, in time and manner directed by Covered Entity, any and all information sufficient to permit Covered Entity to respond to any request from Individual for an accounting of disclosures pursuant to 45 CFR 164.528.

(m) To maintain appropriate administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule.

(n) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and

(o) Business Associate agrees to notify Covered Entity of any use or disclosure of Protected Health Information by Business Associate not permitted by this Agreement, or of any Breach (as defined in 45 CFR 164.402) of Unsecured Protected Health Information (as defined in 45 CFR 164.402).

1. Business Associate shall provide the following information to Covered Entity within ten (10) business days of discovery of a breach related to the information of one or more individuals whose group vision coverage is arranged by Covered Entity, except when despite all reasonable efforts by Business Associate to obtain the information required, circumstances beyond the control of the Business Associate necessitate additional time. Under such circumstances Business Associate shall provide to Covered Entity the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) calendar days from the date of discovery of a breach:
   a. the date of the breach;
   b. the date of the discovery of the breach;
   c. a description of the types of unsecured Protected Health Information that were involved;
   d. identification of each individual who is enrolled in the group vision plan administered on behalf of Covered Entity and whose unsecured Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, or disclosed.
   e. any other details necessary to complete an assessment of the risk of harm to the individual; and,
   f. a description of what has been done to cease the immediate loss of data along with any associated long-term data loss prevention measures which are being developed.
2. Covered Entity will be responsible to provide notification to individuals whose unsecured Protected Health Information has been improperly disclosed by Covered Entity, as well as the Secretary and the media, as required by Sec. 13402 of the HITECH Act, 42 U.S.C.A. § 17932.
3. Business Associate agrees to establish procedures to investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to Covered Entity in the time and manner reasonably requested by Covered Entity.

3. General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity, provided that such use or disclosure by would not violate the Privacy Rule if done by Covered Entity.

4. Obligations of Covered Entity

Covered Entity shall:

(a) Make available to Business Associate, the notice of privacy practices, and changes thereto, that Covered Entity produces in accordance with 45 CFR 164.520.

(b) Provide Business Associate with any changes in, or revocation of, permission by Individual, to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.

(c) Notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522.

5. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

6. Term and Termination

(a) Term. This Agreement shall be effective as of the date of execution hereof, and shall terminate when all of the Protected Health Information is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy such Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.

(b) Termination for Cause. Upon Covered Entity's actual knowledge of a material breach by Business Associate to the terms of this Agreement, Covered Entity may provide Business Associate with a reasonable opportunity to cure such breach, or terminate this Agreement.

(c) Effect of Termination. (1) Except as provided herein, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information. This provision shall apply to Protected Health Information in the possession of any agents or subcontractors Business Associate. Business Associate shall not retain any copy(ies) of the Protected Health Information. (2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to

Covered Entity notification of the conditions that make such return or destruction infeasible. Upon mutual further agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit all further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

7. Other

(a) Business Associate hereby agrees to indemnify, defend, and hold harmless the Covered Entity (including without limitation, its employees, agents, successors, assign, officers and elected officials) from and against any and all claims, causes of action, liabilities, damages, costs or expenses (including without limitation, reasonable attorneys' fees, court costs of administrative or other proceedings, and costs of investigation) arising out of or related to a breach of any of the terms and provisions of this Agreement by Business Associate or any party acting by or through Business Associate (including, without limitation, Business Associate's agents, employees, representatives, contractor or subcontractors).

(b) This Agreement is entered into by and among the Covered Party and the Business Associates for the exclusive benefit of each of the parties hereto. This Agreement shall not be construed to confer any rights or remedies upon any Person, except the parties hereto and their respective officers, directors, shareholders, employees, agents successors, and assigns.

8. Miscellaneous

(a) Regulatory References. Any reference in this Agreement to a section in the Privacy Rule means the section as then in effect, or as amended, and for which compliance is required.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement, from time to time, as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

(c) Survival. The respective rights and obligations of Business Associate under this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

JAMES M. McGRANN **SECRETARY**	**Mayor Tommy Battle** **Mayor, City of Huntsville**	**Clerk-Treasurer**

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